Authorization to Disclose Health Information

New Alternatives, Inc.

_____	_____	_____
(Print Name)	(DOB)	(Social Security Number)

I authorize the use and disclosure of information identified on this form of the individual above,

Between: New Alternatives, Inc.
Therapeutic Behavioral Services

And: _____
_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an authorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I may contact: Kelsey Peck, TBS Program Manager, at (619) 615-0701.

The disclosure of health information and records authorized herein is required for the following purpose: Determination of eligibility for Therapeutic Behavioral Services (TBS) and/or TBS delivery.

I specifically request the following information be released:

- __X__ Diagnosis
- __X__ Mental Health Evaluation
- __X__ Quarterly Reports
- __X__ Psychological evaluation
- __X__ Legal Information
- __X__ Intake/Discharge Summary
- _____ History & Physical exam
- __X__ Treatment Plan/Service Plan
- __X__ Psychiatric Assessment
- __X__ Other: Exchange necessary information to evaluate for and/or implement TBS.

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to: Kelsey Peck. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: 1 year.

I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

_____	_____
(Signature of client)	(Date)
_____	_____
(Signature of parent/guardian)	(Date)
_____	_____
(Signature of witness)	(Date)